Integrated Health Partnerships 2017 Request for Proposal Payment & Risk Models

Mathew Spaan | Manager, Care Delivery & Payment Reform

mathew.spaan@state.mn.us

July 20, 2017

DEPARTMENT OF HUMAN SERVICES

Additional Informational Opportunities

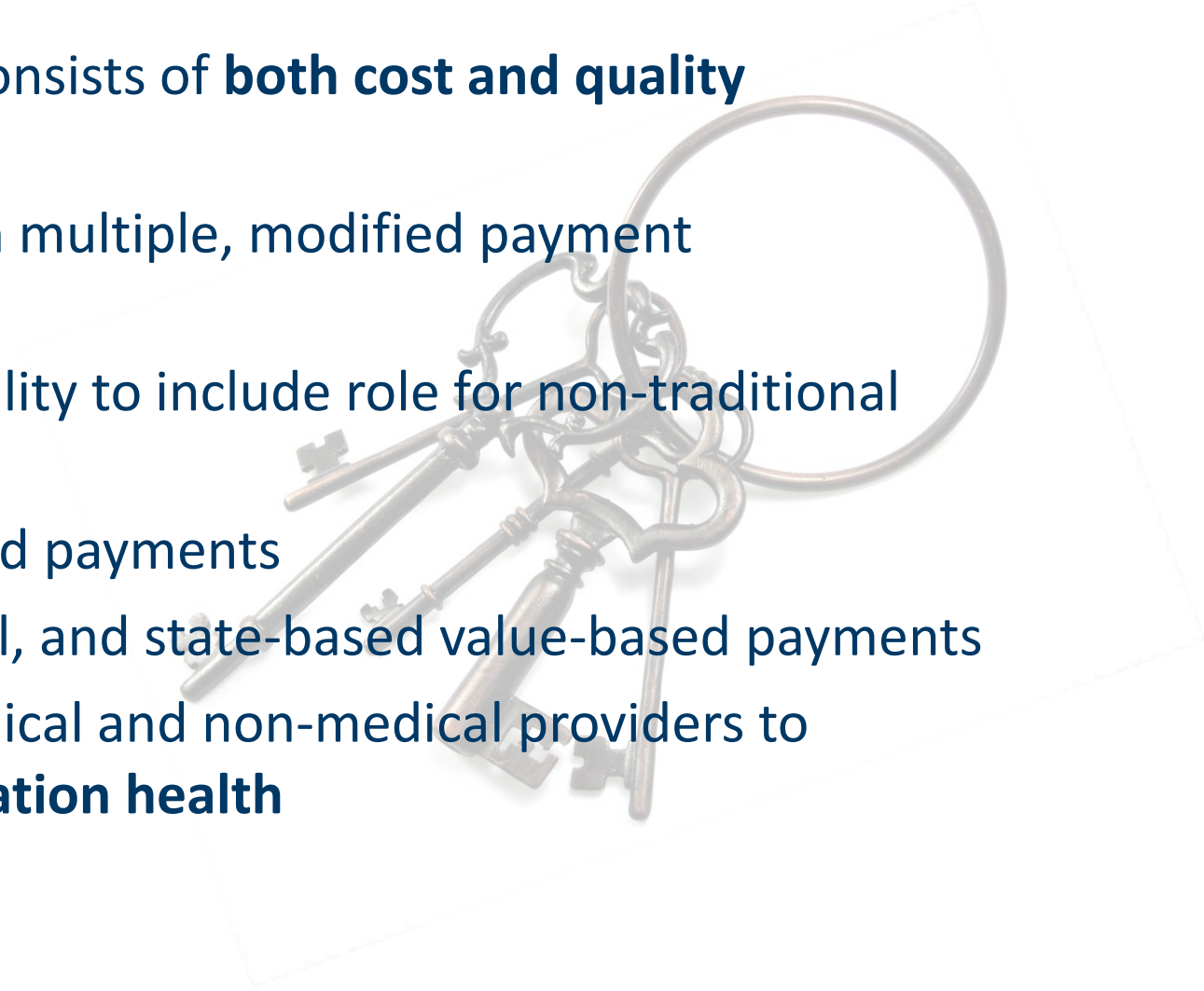
- IHP RFP **website** - http://www.dhs.state.mn.us/DHS-293927
- **Prior Webinars**
  - Overview of RFP process and new IHP model
    June 29, 2017
  - Quality & performance measurement
    July 11, 2017
  - Slides available at http://www.dhs.state.mn.us/DHS-293927
- **Written questions** – submit to dhs.ihp@state.mn.us by July 25th, responses published ~August 1st
- DHS's IHP **listserv** - Subscribe here

Today's Agenda

- Overview of core principles of Integrated Health Partnerships (IHP) value based payment in the IHP 2.0 model
- Review payment methods under IHP 2.0 model
  - Beneficiary eligibility and attribution
  - Population-based payment
  - Total Cost of Care Risk Model
- Questions?

IHP 2.0 | Core Principles of the Payment Methods

- **Value-based payment** arrangement consists of **both cost and quality components**
- **Sustainability and innovation** through multiple, modified payment arrangements
- Emphasis on **primary care**, with flexibility to include role for non-traditional principal care providers
- **Expanding participation** in value-based payments
- **Alignment** with other federal, national, and state-based value-based payments
- Incentivize partnerships between medical and non-medical providers to effectively address **patient and population health**



IHP 2.0 | Multiple Tracks

	Track 1	Track 2
Track Overview	IHP entity will receive a **quarterly population-based payment (PBP)** tied to clinical, utilization, and social determinant metrics adjusted for their attributed population's medical risk and social determinants of health	IHP entity will receive the **quarterly PBP** *and* enter into a **two-way** risk model for **shared savings/losses**, tied to clinical, patient experience, social determinants, and HIE infrastructure metrics
Requirements	• **Innovative care model** that provide or coordinate full scope of health care services • **Demonstrated ability** to impact TCOC, coordinate care, improve quality ****Health Care Homes, NCQA cert., other evidence****	Same as Track 1, plus: • Ability to take on financial risk (based on multiple factors) • Sufficient population size to reduce potential variability of performance results
Applicable Provider Types	• **Small, independent** provider systems • **Specialty health care groups** that coordinate care for specific groups of individuals or services	• **Mid or large sized integrated health systems or collaborative partnerships** with ability to coordinate and provide the full scope of Medicaid services for attributed patients.
Data and Peer Learning Support	All participating IHPs gain access to **robust data** files and reports, and **peer support** opportunities	

IHP 2.0 | Multiple Payment Arrangements

	Population-based Payment (PBP) Tracks 1 and 2	Total Cost of Care Risk Model Track 2 Only
Attribution	• Includes MA and MNCare, across PMAP and FFS. • Beneficiaries attributed based on up to 24 months look-back period	
Overview	• **Quarterly per member per month (PMPM) payment**, adjusted by risk, social complexity • Care coordination, infrastructure development • Estimated average PMPM rate across all IHPs to be ~1% of attribution eligible population's TCOC PMPM; individual IHP's average rate may differ based on population served • **PBP <u>replaces</u> HCH, in-reach payments**; IHPs still eligible to receive BHH, CCDHC payments	• **Two-sided risk** model –potential for additional revenue through shared savings • Performance period vs. Target based on trended, risk adjusted historical performance • Reciprocal **upside and downside risk** with 50% share of savings in each risk corridor; risk levels may be modified with meaningful partnership • **IHPs may "cap" risk** • Includes wide range of Medicaid covered services and PBP in total cost of care calculations
Quality Impact	• Multiple clinical, health disparities, and utilization measures; **determines participation** after the conclusion of each three-year cycle.	• Core set of measures across clinical, patient experience, social determinant, HIE infrastructure; **impacts 50% of IHP portion of the shared savings** amount but does not influence losses.

Beneficiary Eligibility and Attribution Tracks 1 and 2

IHP 2.0 | Attribution Eligibility and Hierarchy

Eligibility Exclusions (Appendix C-2)**:**

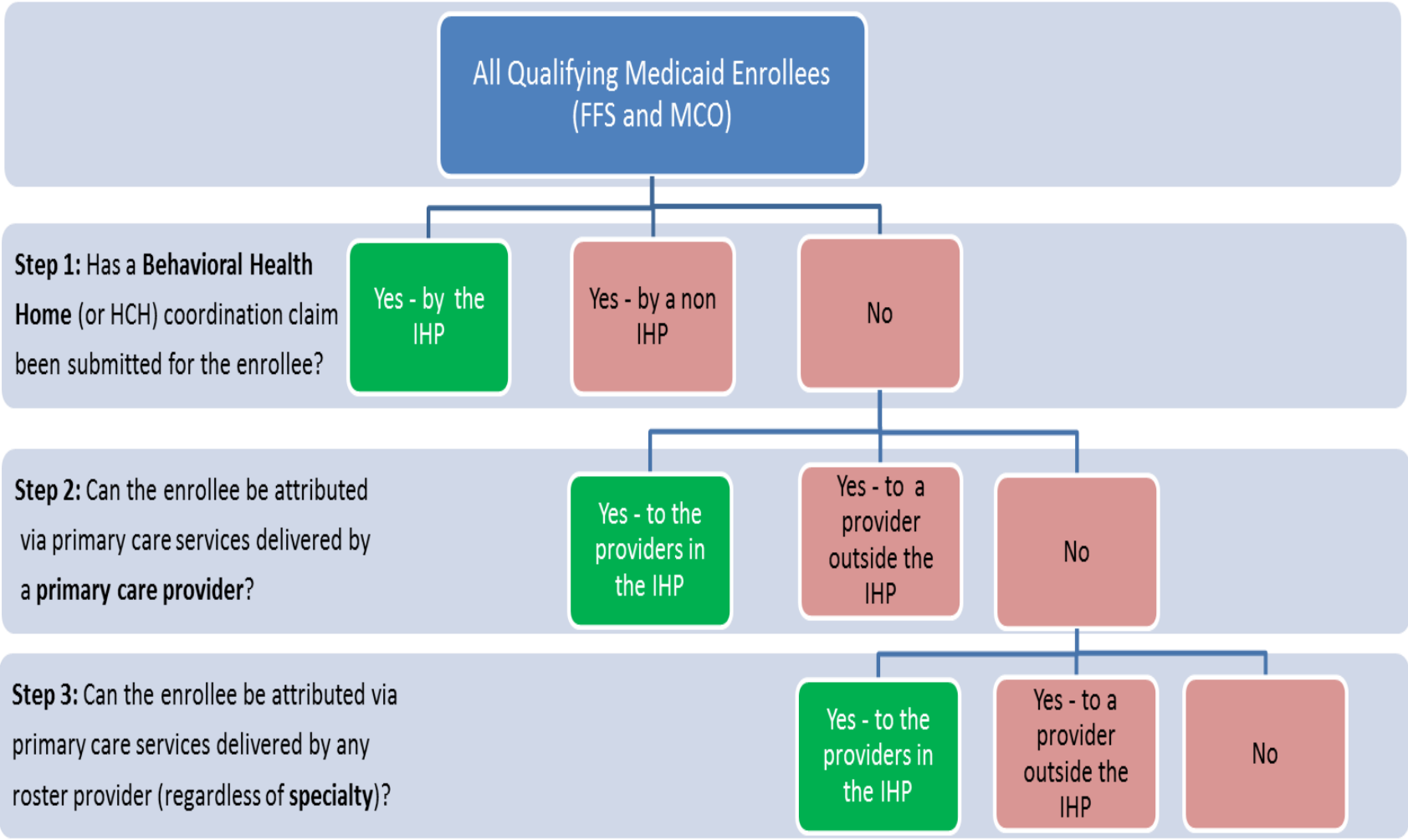
- Members dually eligible for Medicare (either Part A or Part B at any point during the past year)
- Members eligible only through programs that do not have a full benefit set
- Members with additional (third-party) coverage

Durational Exclusions:

- Members must have at least 6 continuous months or 9 non-continuous months of enrollment in an eligible program

Look Back Period:

- 12 months (plus 3 months run-out) initially, with an additional 12 months (24 total) for unattributed beneficiaries



IHP 2.0 | Additional Key Points on Attribution

- For purposes of counting visits, all participating providers as defined by IHP treated as a **combined entity**
- For ties (i.e. same number of E&M visits at multiple entities), the member is attributed to the **entity with the most recent qualifying visit**
- Attribution is run **monthly on a rolling basis** so IHPs can be provided regular updates on status of members
  - For example, **January 2018** attribution will be based on service dates from **October 2016 and September 2017** (plus run-out); **February 2018** attribution will be based on service dates **November 2016 through October 2017**

IHP 2.0 | Attribution & Roster Submission

- A critical component of the process is an **accurate provider roster** form the IHP
- Two roster options
  - **All-in billing provider roster:** Full list of their billing NPIs included in the IHP
  - **Select billing and treating provider roster:** Full list of both the billing NPIs *and* individual treating provider NPIs included in the IHP on a quarterly basis
- Details and roster templates are available in **Appendix A2** of the RFP

Population-Based Payment
Tracks 1 and 2

IHP 2.0 | Population-based Payment (PBP)

- Authorized through MN Stat. **256B.0755, subd. 4(d)** (as amended in 2017 1st Special Session)
- Available to both Track 1 and Track 2 IHPs
- Care coordination, infrastructure development, or other activities **supporting innovative care delivery models** for Medicaid beneficiaries
- **Quarterly per member per month** (PMPM) payment, adjusted by **risk, social complexity**
- Tied to of **clinical, utilization, and social determinant** metrics
- PBP replaces **Health Care Home** and **in-reach** payments
- Does not replace **Behavioral Health Homes** and **Certified Community Behavioral Health Clinic** payments – but beneficiaries "carved out" of PBP calculation
- Included in Track 2 Total Cost of Care performance calculation

IHP 2.0 | Population-based Payment Considerations

- Payment should reflect the **relative risk** and **complexity (clinical and social)** of an IHP's attributed population
- As a population-level payment, the average payment amount should account for diverse risk and complexity ***within*** population, **diverse needs** of beneficiaries served
- Methodology should be **relatively easy to administer and understand** and be reasonably **predictable** across each performance period
- Aggregate payment amount should be **sufficient to help support care management and delivery** requirements without overly **impacting an IHP's ability to achieve shared savings**

IHP 2.0 | Quarterly Population-Based Payment

- **Average payment rate** based on the average of a "member-specific" payment across the attributed population
- PMPM expected to reflect the members' **relative medical risk, impact of social determinants** of health and other factors impacting the intensity of the members' care management needs
- Although the underlying payment levels may vary considerably by member, the average payment across the entire population is expected to be relatively predictable
- Average payment level examples:

	All IHPs	IHP A		IHP B		IHP C	
TCOC PMPM	$403.19	$361.00	vs. Avg	$383.00	vs. Avg	$569.00	vs. Avg
Risk	1.13	0.92	82%	1.08	96%	1.60	142%
PBP PMPM	$4.50	$4.04	90%	$4.41	98%	$5.35	119%
Total PBP (10,000)		$484,654.38		$528,838.69		$641,702.02	
% of TCOC	1.1%	1.1%		1.1%		0.9%	

IHP 2.0 | Population-Based Payment Calculation

Individual member examples

ACG	Description	2015 Months	Risk Weight	Percentile	Payment
5200	Non-Users (2 input files)	150,520	0.0022		$2.00
5110	No Diagnosis or Only Unclassified Diagnosis (2 input files)	124,356	0.0750		$2.00
1600	Preventive/Administrative	206,618	0.0820	10%	$2.00
1000	Chronic Specialty: Stable	1,509	0.0827	483,003	$2.00

ACG	Description	2015 Months	Risk Weight	Percentile	Payment
2700	Acute Minor/Psychosocial, w/ Psychosocial Unstable - 2	6,473	1.3169		$5.34
4520	6-9 Other ADG Combos, Age 1 to 5, 1+ Major ADGs	29,980	1.3852		$5.42
5332	Infants: 6+ ADGs, no Major ADGs, Normal Birth Weight	16,581	1.3875	80%	$5.50
4910	6-9 Other ADG Combos, Age 35+, 0-1 Major ADGs	255,703	1.4035	559,612	$6.41

ACG	Description	2015 Months	Risk Weight	Percentile	Payment
5060	10+ Other ADG Combos, Age 18+, 3 Major ADGs	83,163	5.1512	97.7%	$11.70
5321	Infants: 0-5 ADGs, 1+ Major ADGs, Low Birth Weight	665	6.4290	98,697	$12.15
5030	10+ Other ADG Combos, Age 1 to 17, 2+ Major ADGs	27,678	8.1110		$12.63
5070	10+ Other ADG Combos, Age 18+, 4+ Major ADGs	79,448	10.0984	100%	$15.73
5341	Infants: 6+ ADGs, 1+ Major ADGs, Low Birth Weight	3,617	19.3715	110,743	$30.17

Total Cost of Care Risk Arrangement
Track 2 Only

IHP 2.0 | Total Cost of Care Risk Arrangement

- **Two-sided risk** model – potential for additional revenue through shared savings, in exchange for downside risk
- Generally, similar **upside and downside risk levels,** with 50% share of savings or losses
  - **2% threshold** before any shared losses or gains
  - Shared savings contingent on **quality performance**
  - Risk levels may be modified with **meaningful partnership ("Accountable Care Partnerships")**
- "Total cost of care" includes the **wide range of Medicaid covered services and PBP** for the IHP's attributed population
- **Actual Performance vs. Estimated Target** based on **trended**, **risk adjusted** historical performance
- IHPs may "cap" risk through **risk corridors** (i.e. the band above and below the target for which losses or savings may be paid out)

IHP 2.0 | Accountable Care Partnerships

- Track 2 IHPs may be **eligible for non-reciprocal risk** (i.e. greater upside vs. downside potential), if they enter into formal partnership
- **Ongoing legal relationship** to provide services to address a population health goal; partnerships to be evaluated on:
  - **Substantiveness** of the community partnership
  - Amount of **risk involved** for the IHP and the community partner
  - **Impact** of the community partnership on the total cost and/or quality of care
- Must include **letter(s) of support** from partners; sample agreement
- Track 1 IHPs may also act as an “accountable care partner” with a Track 2 IHP

IHP 2.0 | Total Cost of Care Performance Calculation

Basic Calculation

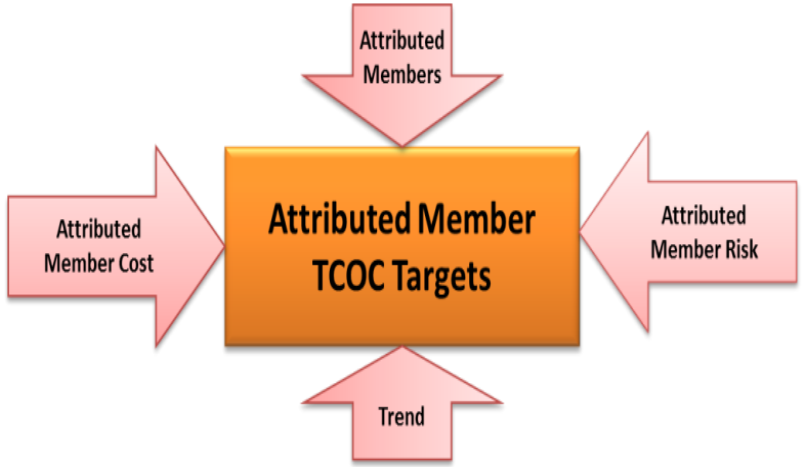
- TCOC **target** is compared to IHPs **actual experience** to determine the level of claim cost savings (excess cost) for risk share distribution

Target Development

- Calculate the **relative risk** for the attributed members for **base period** (i.e. CY2017)
- Calculate the **TCOC** for the base period
- Apply a claim/medical **cost trend factor**

Results Assessment

- Calculate the **relative risk** for the attributed members for performance period (i.e. CY2018, 2019, or 2020)
- Adjust target for the **change in relative risk**
- Calculate **TCOC** for the performance period
- Compare the adjusted target to the TCOC results



IHP 2.0 | Medical Risk Adjustment Methodology

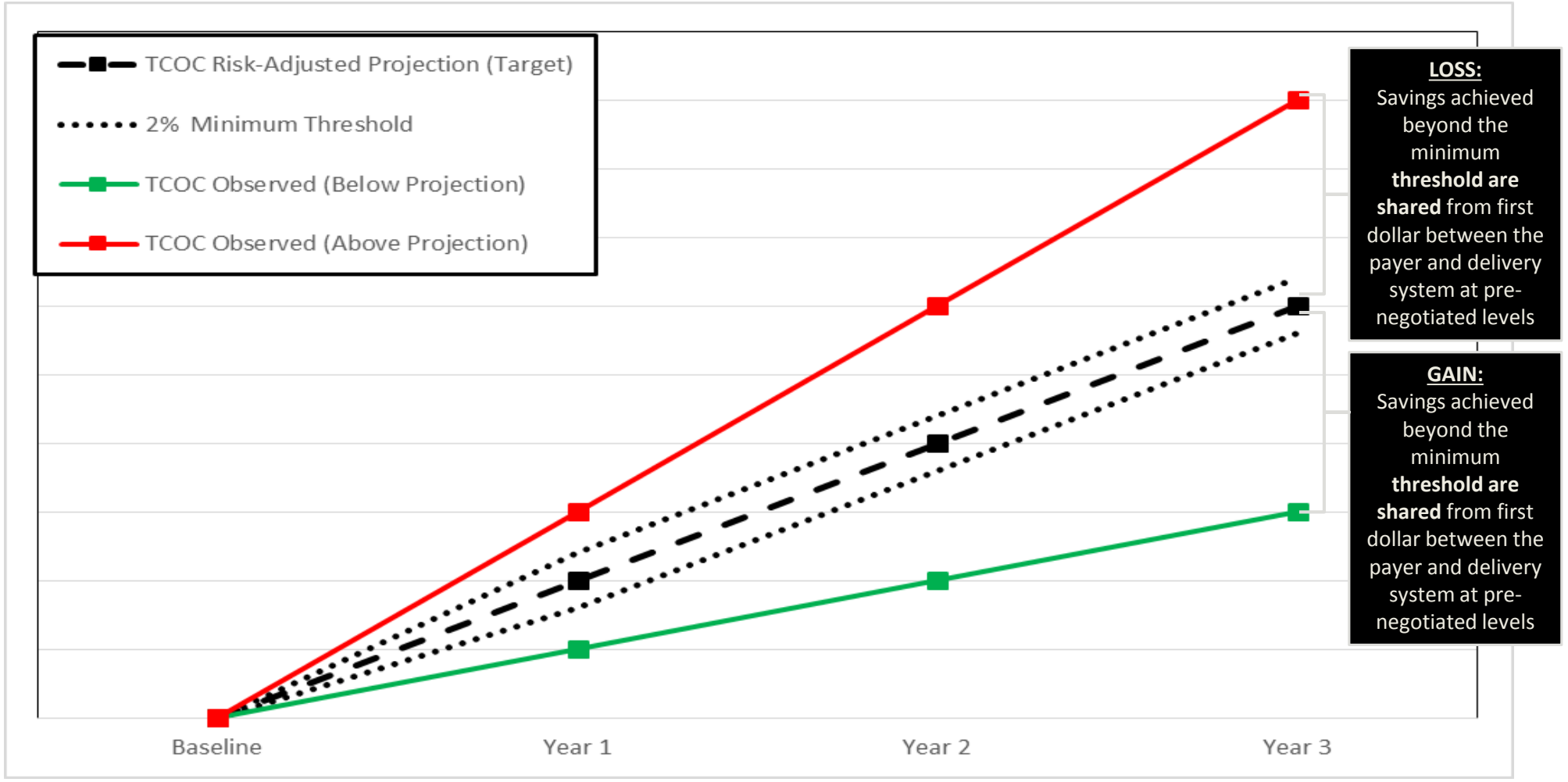
Goals of Risk Adjustment

- **Reduce variability** of results driven by catastrophic cases, durational eligibility issues and other characteristics of the attribution eligible populations
- Retain a reasonable level of claims **responsibility gain-share opportunity** for IHPs

Basic steps for assessing IHP attributed population's relative risk

1. Assign each member to a specific risk category
2. **Johns Hopkins ACG Case Mix System** assigns each member to one of 94 categories based on the member's diagnosis information, age and gender
3. Members with the same ACG assignment assumed to have similar "expected risk for healthcare"
4. Determine average cost for the members in each ACG category. Average cost = "Expected cost"
5. Determine aggregate expected cost for an IHP's attributed population
6. Compare the population's expected cost to the average expected cost across the program to determine the relative risk

IHP 2.0 | TCOC Simple Illustration



IHP 2.0 | TCOC Anticipated Payment Timeline

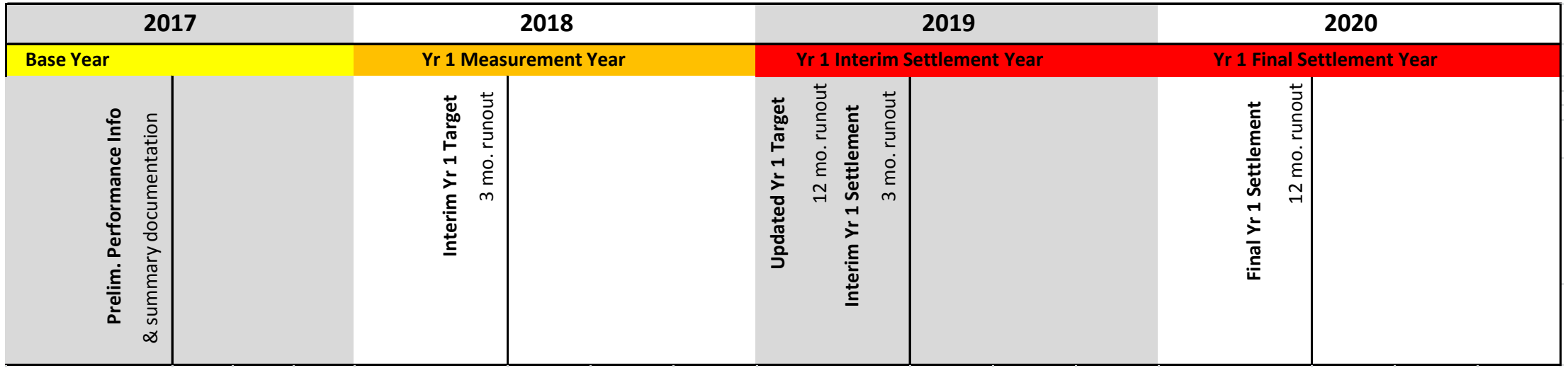
Baseline year – CY2017

- **Interim targets** developed in Spring 2018
- **Final targets** confirmed in Spring 2019

1st Performance year – CY2018

- **Interim settlements** developed in Spring 2019
- **Final settlements** developed in Spring 2020

Timing of settlements balancing the need for sufficient claims runout, efficiency of operation, and providing timely performance information to the IHPs



IHP RFP Process | How to Respond

- Letter of Intent (Appendix A-1)
  - Due August 18th, 4:30 pm (Central), via e-mail to Mathew.Spaan@state.mn.us
    1. Organizational information and primary contact
    2. Past experience in value-based purchasing (ex. IHP, MSSP, other ACO or VBP programs)
    3. Certifications at the participating clinics or system level (ex. HCH, NCQA ACO, PCMH)
    4. Intended track
    5. Why interested in participating in IHP program
- Application (Appendix A)
  - Hard copies must be received by DHS by September 1st, 4:30 pm (Central).

Attention: Mathew Spaan
Health Care Administration
Department of Human Services
444 Lafayette Road N.
St. Paul, MN 55155

IHP RFP Process | Key RFP and Contracting Dates

ACTIVITY	DATE
Letter of Intent Due	August 18th, 2017
Proposal Responses Due	September 1st, 2017
RFP Review/Evaluation	~September 15th, 2017
Notice of Intent to Contract	~September 21st, 2017
Potential IHP Plenary Sessions	~Sept. 18th – Sept. 30th, 2017
Individual IHP Contract Negotiations Begin	~September 25th, 2017
Individual Reports to Potential IHPs	~September 29th, 2017
2018 IHP Contracts Executed	~December 15th, 2017
Performance period begins	**January 1, 2018**

Thank you!

Mathew Spaan

Manager, Care Delivery & Payment Reform

mathew.spaan@state.mn.us